
# LONG-TERM CARE: FUTURE PROVISION AND FUNDING

## GOVERNMENT RESPONSE TO THE THIRD REPORT FROM THE HEALTH COMMITTEE SESSION 1995–96

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# RESPONSE TO HEALTH SELECT COMMITTEE THIRD REPORT ON LONG-TERM CARE

**Introduction**

The Government welcomes this careful and considered report on a very important subject which makes a valuable input to the debate on long-term care. In particular, we welcome the Committee's strong endorsement of the objectives of the Community Care reforms. The Committee makes a number of important recommendations for further work and action which the Government will study carefully.

The Government notes the Committee's acceptance of its projections on the affordability of paying for long-term care in the future, at least up to about 2030. It fully endorses the view expressed by the Committee that radical changes to the current system of funding long-term care touch upon fundamental questions concerning the future of the Welfare State, and cannot be tackled in relation to long-term care in isolation.

The Government believes that the current system of funding long-term care is sustainable for the foreseeable future, and will continue to keep the system under regular review.

The Department of Health is responding to the Health Select Committee on behalf of the Government.

**Recommendation 1**

**There has been considerable media and public speculation about the "crisis" the country supposedly faces in paying for long-term care in the future. We believe that much of this speculation has been founded on unsound evidence, or indeed been downright alarmist, and that the problems the country faces in relation to long-term care, although real, are more manageable than many recent commentators have suggested. (Para 9)**

The Government agrees with the Health Committee's view.

**Recommendation 2**

**In our First Report we drew attention to the difficulties which have arisen when home charges exceed the preserved rights figure. We recommend that "the DoH seek evidence from all local authorities as to the current scale of the problem...and in consort with the DSS, conduct a review of the existing arrangements...with the aim of ensuring that no elderly residents should face eviction in the future. " In response the DoH stated that "local authorities and the DoH are not in direct contact with the majority who have preserved rights...as they remain the responsibility of the DSS." We are very disappointed with the Government's response, which attempts to shuffle off responsibility and does nothing to meet the needs of some of the most vulnerable members of society. We repeat our recommendation that the DoH, in conjunction with the DSS, should review the situation. (Para 20).**

The Government has given careful consideration to this issue, and is of the opinion that whilst there may be differences in some areas between fee levels and the Income Support limits for those who have preserved rights, this does not constitute a major or national problem. Furthermore we consider that the current provisions do contain sufficient protection for any elderly people facing difficulties by enabling local authorities to intervene in certain circumstances. DSS Ministers review the level of the preserved rights limits each year taking account of the pressures on each of the limits. The limit for elderly people in residential care homes increased by 15% in real terms between April 1985 and April 1996, and in nursing homes by 36%.

**Recommendation 3**

**There is a clear trend towards the provision of high-intensity home care services, both in terms of the numbers of contact hours provided and in the numbers of visits made. While we welcome the development of packages of care which allow more people with high levels of dependency to be cared for in their own home, if they so wish, we would not expect local authorities, health authorities and housing agencies to lose sight of the fact that preventative services can play an important role in delaying, or reducing, the demand for long-term care in some cases. It is potentially counter productive for authorities not to invest in preventative services, as this may only lead to the earliest onset of the demand for long-term care, often at a "crisis point" in the life of an individual needing care. (Para 37)**

The central aim of Government policy for the care of elderly people is to promote services that enable them to enjoy active, fulfilling and independent lives and to remain in their own homes for as long as is practicable and desired. The objective is to encourage high quality domiciliary and community-based services tailored to individual need, backed up by well-appointed and well supported residential care, to keep any spells in hospital to a minimum consistent with good treatment, and to promote effective rehabilitation.

**Recommendation 4**

**It is particularly important that the full value of a properly arranged home-help service is understood. There are merits in such a service whether or not it serves to delay the need for institutional long-term care. There are many people who may benefit, in terms of continuing to live independently in their own home, from relatively low levels of domiciliary services, such as cleaning and other basic housekeeping services. We are concerned by Professor Tinker's evidence suggesting that basic cleaning services are often now unavailable. For an old or disabled person, help in cleaning the house is often at least as important as help with shopping, both because it assuages the mental anxiety and loss of self-esteem that may follow from inability to keep a house clean, and because it is easier to ask neighbours or relatives to go on shopping errands than it is to ask them to undertake basic cleaning tasks. We believe that local authorities should ensure that they take account of the wishes of service users as to the type of services that are arranged on their behalf. (Para 38)**

Decisions about the provision and management of personal social services, including home care, are the responsibility of local authority social services departments. They are responsible for assessing the need for services in individual cases and for deciding how these may most appropriately be met. Over the past several years many local authorities have remodelled their home help services and have changed from the traditional home help system, which provided mainly domestic duties such as cleaning and shopping, to a home care service able to provide a greater degree of more personal care. This change in emphasis is intended to help highly dependent people to continue to live in the community in a home of their own. The change has meant that services are more flexible and can be targeted more accurately.

**Recommendation 5**

**We are convinced that care services such as those available through the Belfast Intensive Homecare Scheme could be successfully provided on a wide scale in England. (Para 43)**

Our community care reforms have re-emphasised the need for health, housing and social services departments to work closely together to provide well knit services. No one agency can meet the totality of an individual's needs when these are complex and long term. As the Committee has recognised this is not an easy process. Authorities are approaching these complex questions by developing integrated commissioning strategies. The DoH has assisted them in this process by issuing guidance on joint commissioning in 1995 and are currently undertaking development work.

**Recommendation 6**

**We endorse the objectives of the Community Care reforms, those of promoting personal choice wherever possible and enabling people to live independently in the community. We have noted the great value to many elderly and disabled people, both in preventative and other terms, of relatively low-intensity domiciliary services such as cleaning. We also welcome the extension of opportunity for people with higher levels of dependency to be looked after in their own homes, if this is their wish. There will, of course, always have to be a judgement made as to what is the level of cost above which domiciliary care packages cease to be realistically affordable, bearing in mind the equally valid needs of other people in the wider community. The question of where to locate this cut-off point is a difficult one, and we can understand why the Government has decided that it is a matter best left to local discretion. Our own view is that a cut-off point at about the cost of a nursing-care place is not unreasonable, if treated as a guideline: and we note the success of the Belfast Intensive Homecare Scheme in providing a high level of service within this cost constraint. We do, however, believe, that there should be local discretion to exceed this limit in circumstances deemed to be exceptional. The wishes of service users should be taken fully into account in any decisions over the level of domiciliary care to be provided: for instance, some people may prefer to receive care in a communal setting due to the greater opportunities for social interaction that such a setting can provide. (para 44).**

The Government welcomes the Committee's acceptance that this is an issue best left to local authorities to decide.

**Recommendation 7**

**It is crucially important that the charging system should not contain perverse incentives for local authorities to steer individuals towards residential rather than domiciliary care (or indeed, for that matter, for individuals to opt for home care on financial grounds if this is not in their own best interests). (Para 46).**

The Government is aware that there could be a perverse incentive (due to differences in the way users are charged for domiciliary and residential care) whereby financial considerations take precedence in the assessment of care needs and provision of services. The Government's view is that the first priority in assessing care needs and drawing up care plans should be the appropriateness and suitability of provision in each individual case. The Social Services Inspectorate of the DoH have issued guidance on assessment and care planning which emphasises the importance of basing service provision on the needs and wishes of users.

**Recommendation 8**

**Evidence taken in the second phase of our inquiry further supports our view that a shift in thinking towards rehabilitative solutions is desirable. We wholly agree with the ADSS that the public debate about the future of long-term care has placed too much emphasis on institutional solutions and has downplayed the potential of rehabilitative services. We repeat the call we made in our earlier report for the NHS to place greater emphasis on rehabilitation, domiciliary and health promotion services. It is perhaps not unreasonable that in the three years following local authorities' assumption of additional responsibilities in April 1993, they should have directed most of their managerial effort at the commissioning and purchasing of residential and nursing-home places. Henceforward, however, they should show more flexibility in their provision of care packages, and we recommend that the DoH should take steps to encourage them to do so. In particular, we believe that all local authorities should be asked to give serious consideration to the setting up of social rehabilitation schemes along the lines of those to which the SSI has drawn attention. We believe that authorities should seek to purchase an increasing number of short- term rehabilitative services and respite care services from local care providers, both public and private. We also believe that necessary measures should be taken to preserve people's rights of access to their own home for a reasonable time after entering care. (paras 49 and 55)**

The Government welcomes the Committee's recommendation and the positive support it is giving to the development of rehabilitative services. The Government agrees that effective services which support rehabilitation and recovery should improve outcomes for users and carers and help to reduce the demand for long term institutional care. The Government is committed to encouraging both health and local authorities to develop services of this kind. It considers that a flexible approach to the development of services, which is responsive to local needs and circumstances, will be required and the Government will take steps to disseminate good practice. The guidance on NHS responsibilities for meeting continuing health care needs stressed the importance of rehabilitation and recovery services. The NHS Executive and the SSI will use their ongoing review of the implementation of the guidance to ensure further progress is made in this area.

**Recommendation 9**

**We agree with those of our witnesses who felt that housing services are often a neglected part of the community care framework. Housing improvements can offer a happy conjunction of cost-effectiveness for the providing authorities with improved quality of life for those who inhabit the housing. The DoH, in conjunction with the DoE, should take vigorous steps to ensure that housing services fully exploit their potential they have for contributing to the Government's community care objectives, particularly with regard to the development of very sheltered housing schemes and ensuring that ordinary sheltered housing schemes are attractive to the current and future generations of users. The DoH and the DoE should encourage the wider development of collaborative schemes such as community alarm schemes like that operated in Fife and elsewhere. The benefits to be obtained from these and other improvements in housing provision should be taken fully into account as an integral part of future care plans at both local and national level. (para 63)**

Housing must be an important component in community care, a fact fully recognised by both DoE and DoH. In 1992, before the community care reforms came into effect, the two Departments issued a joint circular to housing authorities and social services departments about the interface between housing and community care. Since then we have had a continuing programme of work to encourage joint working between health, housing and social services.

Earlier this year Ministers from the two Departments made a joint policy statement on addressing the housing needs of the elderly in the Housing Corporation publication "Housing for Older People". While we recognise that very sheltered housing may have a role in the range of provision made available to older people, we wish to encourage housing authorities and social services departments to develop strategies that focus on the needs of individual households whose needs may change over time, rather than fixed theoretical categories of need.

**Recommendation 10**

**The DoH expresses concern that some health authorities have proposed eligibility criteria which could operate over-restrictively. We share that concern, and look to the DoH to ensure, through their ongoing review and monitoring programme, that this does not happen. We look forward to receiving regular future reports from the DoH on the implementation of the policy. With regard to other areas of interaction between agencies, we have expressed above our belief that schemes similar to the Intensive Home Scheme in Belfast could operate successfully in England. Nonetheless, the existence of separate functions does, at the least, act as a disincentive to such initiatives and to the seamless provision of services. Whether there is a case for unitary authorities in England along the lines of those in Northern Ireland is too large an issue to be encompassed within the present report, although it is one to which we or our successors in the next Parliament may wish to return. (para 66)**

The NHS Executive and Social Services Inspectorate are committed to an ongoing programme of monitoring and review of the implementation of the

guidance on NHS responsibilities for meeting continuing health care needsand the impact of local eligibility criteria for continuing health care. A programme of work looking at the early impact of the guidance has recently been completed and the results of this will be published shortly. In addition the NHS Executive has begun from April 1996 the collection of a series of high level performance indicators of the health service contribution to community and continuing care. Partnership between health, local authorities and other agencies to support people with long term care needs is a fumdamental principle of the community care arrangements. In particular, there has been a progamme of work to promote joint commissioning betweeen health and local authorities to ensure that an appropriate and comprehensive range of services is available.

**Recommendation 11**

**In our previous report we commented in some detail on the implications of allowing health authorities to set local criteria for eligibility to receive free, NHS funded, long- term care. We argued that these local criteria might create inequity, with individuals in some parts of the country receiving free NHS care whilst others in identical circumstances elsewhere had to contribute towards the cost of care commissioned by local authorities. While recognising that the DoH's recent guidance represented a step in the right direction, we called for the national framework to include *national* eligibility criteria "to define what the NHS, as a national service, will always provide". We are still of this view. (Para 68)**

The Government's response to the Committee's First Report on Long Term Care (Cm3146) set out the Government's commitment to ensuring greater consistency in arrangements for continuing health care. The Government is convinced that, over time, the impact of the guidance on NHS responsibilities for continuing health care should achieve this objective. However given the very great historic variation in the balance and level of local services it does not consider that it would be feasible to introduce national eligibility criteria at this stage without major service disruption and without undermining local flexibility.

**Recommendation 12**

**It must be a matter of concern that many members of the public believe that there has been a deliberate change in the rules governing payment for long-term care. In relation to residential care, the former Parliamentary Under-Secretary of State, Mr Bowis, told us that this was not actually the case. Whether it can be fairly said that the rules regarding payment for nursing home care have not altered is more open to question: as we commented in our earlier report, many people who are now cared for in nursing homes on a means-tested basis would in previous decades have been cared for by the NHS without charge. (Para 78)**

**Recommendation 13**

**While we accept that the desire to pass on an inheritance is an understandable one, it can also be argued that one of the purposes of saving is to save for one's retirement and for unpredictable events. For that reason there is a strong argument that the State should take savings, as well as income, into account when assessing the contribution that individuals should make towards the cost of the residential and domiciliary care services arranged by local authorities, which have always been subject to a means test. Indeed, those individuals' fellow tax-payers might feel justifiably aggrieved if this was not the case. However the situation is complicated by the fact that for many people the majority of their saved wealth takes the form of a housing asset, and although strictly speaking this is no different from any other form of asset, in psychological terms it is different: people think of the house they live in as their home, rather than as an asset in the same way that savings are assets. The fear of losing ones home is compounded by the present difficulty of making use of *part* of the wealth represented by a housing asset: this is an area where equity release schemes may represent the way forward. (para 79)**

**Recommendation 14**

**In our view it is neither equitable nor desirable to create a system which guarantees that *all* assets will be safeguarded for inheritors in *all* circumstances. Nonetheless, policy-makers need to take account of the way patterns of provision, demands upon the state, and public expectations have altered in recent years, and of the widespread perception that the present arrangements for funding long-term care are unfair. (Para 80)**

Since the inception of the welfare state in 1948, there has always been NHS health care free at the point of delivery, and residential social care which has been means-tested, and the 1993 community care changes did not alter that arrangement. The 1993 community care changes broadly continued this principle. However, the boundary between health and social care has shifted over time with continual advances in clinical science and social change. With the improvements in treatments available to remedy disabling conditions people who would in the past have spent indefinite periods in long stay hospitals can now be rehabilitated and discharged home. In addition, the community care reforms have led to greater flexibility in providing domiciliary support to help more people, where practical, to stay in their own homes.

The Government welcomes the Committee's support for the principles underlying the current system of charging, and is pleased to note that it recognises the importance of maintaining a balance of responsibility between taxpayers and individuals in meeting the costs of long-term care. The Government recognises that many people feel strongly about housing assets but considers that the charging rules make allowance in certain cases to protect an individual's housing asset; such as if the former home is still occupied by a spouse, or an elderly or disabled relative. The rules also give local authorities discretion in other similar situations which are not prescribed in regulations.

The Government has listened sympathetically to people's concerns about the perceived unfairness in the current residential charging system, which is why we introduced two important changes in April this year. The capital thresholds for entitlement to local authority support were substantially increased, with the lower threshold more than trebled from £3,000 to £10,000, and the upper threshold doubled from £8,000 to £16,000, enabling people to retain more of their capital assets; and a new rule was introduced to enable married people in residential or nursing home care to pass on 50% of their occupational pension to a dependent spouse. And in addition the Government has consulted about proposals for a partnership scheme which would enable people to protect more of their assets from the means-test.

**Recommendation 15**

**Given the concerns expressed by many of our witnesses over the lack of robust data regarding the situation in the UK, we recommend that the DoH should ensure that further research on the health status of elderly people and the relationship between longevity and morbidity, taking into the account the possible impact of healthier lifestyles, is commissioned and adequately funded. (Para 97)**

The Government agrees that the future health status of elderly people is an important but controversial issue. The DoH commissioned research on health expectancy, the results of which were published by HMSO in 1995. The Department also commissioned an analysis of past trends in dependency among elderly people, the results of which were published by ONS in 1996. The Department set up an expert Working Group on Health Expectancy Measures to advise on the recommendations of the research, especially the recommendation that longitudinal data was required to monitor trends in health expectancy more reliably. The Working Group is expected to provide advice soon.

**Recommendation 16**

**Population forecasts through to the middle years of the next century are in themselves relatively reliable. Unfortunately, the level of future demand for long-term care is dependent not only on the size of the elderly population but also, and crucially, on much more unpredictable factors such as the number of people living alone and the health status of the elderly. The latter depends on the developments which cannot be foreseen such as the extent of medical progress and the degree to which healthier lifestyles are adopted. All attempts to calculate future demand towards the end of the lifetimes of those who are now young therefore contain an element of crystal ball gazing. A number of witnesses, including the former Parliamentary Under-Secretary of State, Mr Bowis, referred, using a statisticians' term, to an 'expanding funnel of doubt' when projecting so far into the future. One thing clearly emerges from our evidence. This is that the demographic and dependency ratio trends do not bear out suggestions that major problems are looming in the short to medium term, by which we mean the period through to about 2020. After this period the trends may present more of a challenge. (Para 98)**

**Recommendation 17**

**It is extremely difficult to make reliable projections of the future costs of long-term care over a period of 30 to 40 years, owing to the large number of variables that must be considered and a lack of evidence as to which way trends are moving for some key variables, such as the future incidence of disability amongst the current generation of middle-aged people. (para 99)**

**Recommendation 18**

**We discuss some recent projections of the future cost of long-term care, in the interests of giving a full picture of recent public debate. We do not endorse any of the projections, and indeed we are very sceptical about some of them, particularly those which combine in what we think is a confusing way the *actual* costs of long-term care incurred by the State and by individuals, and the *imputed* costs of providing informal care (itself valued in these projections at £7 an hour, which is arguably too high a rate). (para 100)**

**Recommendation 19**

**The overall conclusion drawn by the DoH is that "on almost every scenario... the absolute demand for long-term care is likely to rise steadily over the period, as is the real cost". This will not, however, in the view of the DoH, necessary lead to long-term care becoming unaffordable. Although the projections spanned a wide range of possibilities, almost all of the outcomes imply future rates of increase which are lower than those accommodated over the past 15 years. They do not support claims that we face a 'demographic timebomb', or at least not one that is likely to explode over the next two to three decades. (para 113, 114 and 116)**

**Recommendation 20**

**We are concerned at the lack of good information on likely changes in the health status of elderly people, and we feel that there is also scope for more research as to what impact improvements in preventative and rehabilitation services could have in alleviating some of the additional demand for long-term care that will inevitably occur as the population ages. We recommend that the DoH commission research on both these areas. (para 117)**

**Recommendation 21**

**It is clear from the evidence presented to us that there is highly unlikely to be a dramatic surge in the numbers of elderly people needing long-term care in the period up till 2020. The DoH's central projections indicate that the costs to the taxpayer of providing long-term care services are affordable up until 2031 (the furthest point to which DoH projections have been taken). Many unofficial**

**estimates showing spiralling future costs rest on estimates of the 'cost' of informal care which are unverifiable, probably inflated, and in any case only relevant in relation to that element of care, of unknown extent, which is now provided informally but in future may have to be provided formally. (para 119)**

The Government agrees that it is difficult to make reliable projections of the future costs of long-term care over a period of 30 to 40 years. The DoH's supplementary memorandum showed the extent to which projections of public expenditure on long term care are sensitive to assumptions on some key factors, including future rates of disability and future real costs of care. It also showed that, on assumptions that could be considered plausible, public expenditure on long term care would account for a similar proportion of national resources (GDP) in 2030 as in 1995.

The Government agrees that imputing a cost of informal care is problematic. Informal carers have a crucial role and their contribution is very valuable. Placing a specific figure on that value is not straightforward.

The Government agrees that more research on the effectiveness of service interventions is needed, and the DoH has taken active steps to review priorities for new research on long- term care. Plans are currently in hand to commission a major new research initiative on community health services, to include (subject to satisfactory research proposals) research on rehabilitation and the cost-effectiveness of providing preventive care through early interventions. This will be complemented by a planned new research initiative on outcomes of social care for adults, to include issues of quality, costs and outcomes of long- term care. These research initiatives have been put out to open competitive tender, and final funding decisions are expected by the end of the year.

**Recommendation 22**

**However, the demographic trends in the middle decades of the next century indicate that there may be significant increases in cost in that period. Possible options for minimising these costs include improvements in preventative and rehabilitation services, although as we have already pointed out there is a lack of hard evidence about the cost-effectiveness of such approaches. We do have an extended window of opportunity within which plans for dealing with this eventuality can be drawn up. (para 120)**

The Government is actively committed to a positive health promotion policy for people of all ages and from all ethnic backgrounds. This policy is promulgated through a number of initiatives:

- The Health of the Nation, which was published in 1992, is a strategic plan aimed at achieving better health for everyone in England. The plan sets out, for the first time, targets for improving the nation's health aimed at increasing life expectancy and extending the years free of disability and disease.
- The GP contract requires a three yearly health check on request for those aged 16-74 years and an offer of an annual check up for those aged 75+ years. In addition, GP practices are encouraged to develop annual programmes of health promotion activities designed to meet the local population needs, focusing on Health of the Nation key areas, all of which have important bearings on the health of elderly people.
- A recently published revised version of the booklet "Health and Well-being: A Guide for Older People" includes sections on healthy lifestyles, common health concerns, mental health, carers and safety and security in the home, and is widely available from GPs' surgeries, dentists, pharmacists, Citizens' Advice Bureaux etc.
- The Department of Health funds a number of initiatives aimed at promoting a healthy life-style among older people. These include Age Concern (England)'s "Age Well" and "Senior Health Mentors" programmes.

**Recommendation 23**

**The question which remains to be addressed is whether it is necessary in the comparatively short term, let us say during the period of the next Parliament or its successor, to undertake radical changes to the present system of financing long-term care. We received much evidence from those urging such changes. A general point about our adopted approach should be made. Although we deal at some length with the pros and cons of alternative funding options, we are very much aware that a major option in its own right is to maintain the status quo, and continue with the current system whereby general taxation is used to provide NHS care free at the point of delivery and social care subject to a means test. In order fairly to represent the evidence submitted to us we will discuss in detail the various alternative funding options, but this should not be taken as indicating an assumption on our part that the status quo must be unsustainable and the only argument is about what should replace it. No such assumption has been made. (para 121)**

**Recommendation 24**

**We believe that any changes to present models of care and methods of financing long- term care should conform to the following key principles.**

- **Principle 1: Any changes should maximise independence, self-respect and choice for the individual.**
- **Principle 2: Any changes should be understandable and perceived as equitable.**
- **Principle 3: Any changes should improve the way in which long-term care is planned, organised and purchased by multidisciplinary knowledge-based agencies.**
- **Principle 4: Any changes should provide better support and encouragement to informal carers both in terms of practical help (e.g. training, respite care) and financial help.**
- **Principle 5: Any changes should include mechanisms to ensure that an efficient and high quality service is provided in all care settings.**
- **Principle 6: Any changes should be affordable.**
- **Principle 7: Any new programme of public expenditure on long-term care should, in the cases of services provided or paid for by the NHS, as now be available equally to all citizens according to their assessed need for care; and, in the case of means-tested social care services, be designed to meet necessary care need for citizens who have insufficient income or capital to pay for such care from their own resources. (Paras 125 to 131)**

The Government welcomes this thoughtful contribution to the debate about funding long-term care, and notes that the principles the Committee has outlined have a lot in common with the principles underlying community care that the Government outlined in the "Caring for People" White Paper in 1989 (CM 849).

**Recommendation 25**

**We...recommend that the concept of NHS nursing homes (or NHS provided places) should be maintained and they should be provided when possible. (Para 135)**

The guidance on NHS responsibilities for meeting continuing health care needs makes it clear that health authorities will need to purchase some places for people who meet the eligibility criteria for continuing inpatient care. In purchasing such places they should take account of the levels of care and supervision which such individuals will require. Where such care is purchased will vary depending on what facilities are available locally which may be in NHS hospitals or nursing homes or in nursing homes provided by the independent sector.

**Recommendation 26**

**Of these various proposals, we believe that the RCN suggestion that the nursing costs of long-term care should be the responsibility of the NHS is the most immediately attractive in terms of equity. It has the merit that it would tackle the most manifest unfairness of the present system, the way "health care" is currently defined to exclude 'nursing care in nursing homes'. Many members of the public quite understandably find this definition baffling. It is clearly illogical and indefensible that whereas someone who is ill in a hospital acute ward receives free nursing care, another person with similar medical problems who is cared for in a nursing home is means-tested for their nursing care. As the RCN points out, this means that the "physical location, rather than the individual's needs, determines whether or not the NHS pays for care". Given that the majority of people in nursing homes are elderly people, the effect of the present system is to discriminate on grounds of age. However, the costing of this option is problematic. In putting forward its estimate that implementing the option in England would cost the taxpayer an extra £180 million per annum, the Government emphasises that this calculation is "based on current patterns of care and make[s] no allowance for possible increases in take-up of places nor any effect of increases in fees if there is a large demand effect". We recommend further early examination of and consultation on this proposal. (Para 138)**

The Government welcomes the RCN's contribution to the debate on long-term care funding. It will keep this proposal under review but it does not believe that it currently represents the highest priority for extra NHS expenditure.

**Recommendation 27**

**One difficulty in assessing the relative merits of the options which have been canvassed before us is that it is not yet possible to compare their estimated costs to the public purse with those of partnership schemes, the Government's own preferred option for tackling the problems of long-term care funding. We asked the Government to supply us with their current best estimate of the cost of the various partnership schemes proposed in their discussion document, but received a reply that "it would not be meaningful to produce an estimate until the points made in responses to the consultation paper have been studied and details of the scheme have been settled". Later in this report we express our concern that the Government has issued a discussion paper on partnership schemes without producing a range of estimates of the public expenditure implications of this policy option. (para 139)**

**Recommendation 28**

**The present low uptake of long-term care insurance makes it difficult to judge its potential for future expansion. Such insurance is at present too expensive for more than a small minority of the population to contemplate: PPP Lifetime Care plc described their client profile as people belonging to socio-economic groups AB, frequently retired from professional or vocational occupations, usually owning their home outright and often possessing an asset base of around £250,000. Witnesses from ABI told us that this probably represents the upper end of the market, and that some companies offered less ambitious but more affordable policies; nonetheless, the fact remains that such policies are out of reach of the pockets of most people. Even an expansion of the number of policy-holders will not in itself lead to lower premiums. (para 151)**

These points are addressed in the response to recommendations 30 to 32.

**Recommendation 29**

**We believe that it is essential that the long-term care insurance market is subject to formal regulation, either through the Financial Services Act 1986 or by some other means. This may cause problems of definition, in that it will be necessary to define long-term care insurance so as to distinguish it from medical insurance, but we consider that such problems can be overcome. The need for regulation rests partly on the sheer size of financial commitment for the individual arising from this form of insurance. We also note the views of witnesses from the**

**insurance industry itself, who consider that long-term care insurance will not "take off" commercially until the public is reassured that they are protected against the kind of unscrupulous practices which took place some years ago in respect of the selling of personal pension plans. We were told that there is, ominously, "already evidence that the sale of long-term care is attracting individuals and companies who see the lack of regulation as attractive". For these reasons we strongly recommend that the Government takes the necessary steps to set up an enforceable system of regulation to ensure that individuals are protected against unscrupulous practice and that they can be reassured that insurance packages offered will be appropriate to their needs and financial circumstances. (para 152)**

The Treasury announced on 24 July that responses to "A New Partnership for Care in Old Age" suggest a consensus in favour of regulation of the marketing and selling of long term care insurance under the Financial Services Act 1986 (FSA), and that before taking a decision the Treasury would consult on detailed proposals to bring long term care insurance within the scope of the FSA.

**Recommendation 30**

**We asked the DoH to provide further examples of illustrative costs. ...In response the DoH told us that "it is not for the Government to say how much insurance under a partnership scheme might cost any particular individual ...The examples in the consultation paper were intended to illustrate how the partnership scheme might work in practice, not to provide a definitive guide to costs ...". It is difficult to regard this as a reasonable response to our request. We did not ask for "a definitive guide to costs" , but for precisely the same kinds of "examples ... intended to illustrate how the partnership scheme might work in practice" that the Government has already provided in detail in their consultation paper. (paras 164 to 166)**

**Recommendation 31**

**We received a similar answer in response to a request that the DoH provide us with their current best estimates of the cost to the taxpayer of the various partnership options proposed. ... Once again, we cannot regard this as a satisfactory response to our request. Given that eight months have now passed since the Chancellor of the Exchequer announced the Government's interest in partnership schemes, we would regard it as astonishing if the Treasury and the DoH have not worked out a likely range of costs under the different variables which may be applicable. Given also that the Government has stated its wish to consult on the options it proposes and to initiate a national debate, we see no reason why these rough estimates should not be made public. It is ironic that the Government *has* been prepared to give us its estimate of the cost of the RCN's proposal that the nursing-care element of long-term care should be an NHS responsibility, which is not Government policy, but is not prepared to supply their provisional costings of a proposal which they have announced to Parliament as likely to be adopted. (paras 170-171)**

**Recommendation 32**

**In our view partnership schemes may be beneficial for some people: how beneficial, and to whom, will depend on a range of decisions to be taken by Government and by insurance companies. It is important to recognise that the primary purpose of partnership schemes is asset protection rather than long-term care insurance as such. For the foreseeable future many people will be either too poor to be able to afford such schemes, or too lacking in assets to need them. Equally there will be people whose assets are so substantial that to safeguard them by means of a partnership scheme would require over-insurance, a costly option just to get access to State-funded care at some stage in the future. We would be worried by any suggestion that partnership schemes are 'the answer' to the problems of long-term care funding. At best they may form a useful part of an overall package that may include other mechanisms such as equity release**

**schemes, which we discuss later in this report. Experience of partnership schemes in the United States is at too early a stage for meaningful lessons to be drawn for when this is known, or can reasonably be estimated, will it be possible to assess whether partnership schemes offer a greater degree of public benefit than some of the other proposals discussed in this report. We deprecate the Government's failure to provide even rough-and-ready costings of its various options. Until such costings are provided, the taxpayer is in effect being invited to sign a blank cheque. (para 172)**

The Government has made it clear that its partnership proposals are part of a wider strategy for long-term care and will take account of the Committee's comments in finalising the design of the partnership scheme.

The partnership scheme would increase the attractions of insurance which pays out benefits only for a certain period or up to a certain level as this will be easier to price, and will cost less than insurance which pays out indefinitely. It is however for the insurance industry to determine the costs of insurance policies. Premiums are likely to vary according to each individual's circumstances (eg age, sex). Someone who joins the partnership scheme would be able to take out a partnership product which pays out benefits only up to a level which would enable him to protect the assets he wants to preserve. Those with fewer assets to protect would need less insurance than those with more assets to protect. There would be no incentive for people with high levels of assets to over-insure in order to enter the partnership scheme, as there would be other, more suitable insurance products, such as "whole life" insurance available which would enable these people to cover the costs of long-term care without having to spend their capital assets.

In issuing the consultation paper the Government was not asking the taxpayer to sign a blank cheque, but rather inviting comments on a range of proposals. Many of these comments related to aspects of the proposals which would affect the costs, such as the level of protection from means-testing to be given and the likely take up of the scheme. When the Government announces its decisions it will provide full details of the estimated costs of the scheme.

**Recommendation 33**

**We accept that pensions are not likely to prove a suitable vehicle for the funding of long-term care, and that the two categories of pensions and long-term care insurance should be kept separate. This is not to say that a system whereby people pay contributions into a separate fund to cover their long-term care at the same time and in the same way as they make pension contributions might not have practical attractions, depending on what overall system for funding long-term care is chosen. The automatic and regular deduction of small amounts of income, as in taxation, is a relatively painless way of making financial provision, and might be particularly suitable as a means of providing long-term care cover for the younger generations, those under 50. In addition, it is, of course, possible under current arrangements for an individual to take a reduced pension, and a lump sum which could be used to purchase a dedicated long-term care insurance policy. (para 179)**

**Recommendation 34**

**The specific suggestion that pensioners should be allowed to opt for a smaller initial pension in return for a larger pension later on, which would be used to fund the costs of long-term care, seems to us to be flawed. ... It is clear that the variable pension option does not offer a convincing solution to the problem of fully funding long-term care costs, at any rate for other than a minority of rich people. (para 180)**

The Government notes that the Committee concurs with the reservations expressed in the consultation paper "A New Partnership for Care in Old Age" about pension schemes being used to fund long term care. A number of comments were received on this topic in response to the consultation. These are being evaluated at the present time.

**Recommendation 35**

**In our view improved equity-release schemes may have a useful part to play in enabling asset-rich but income-poor people to make provision for their long-term care whilst also protecting a proportion of their assets. They would introduce a flexibility which is lacking in current arrangements. Such schemes would be attractive if they allowed, for instance - to take an example we consider realistic - a couple owning an average-value house to purchase long-term care insurance with a three-year benefit period for about one-fifth of the value of the house. In other words, giving up one- fifth of the value of the house now would protect the remaining four-fifths if this happened in conjunction with a partnership scheme. (para 183)**

**Recommendation 36**

**However, in view of past experience, it is essential that such equity-release schemes should be properly regulated, as part of the wider system of regulation of longer-term care insurance we recommend. The regulation must ensure that schemes fulfil, as a minimum, the following criteria:**

- **the individual concerned should have an absolute right to remain in his or her home as long as he or she wishes;**
- **he or she should have an absolute right to move house, subject to the equity release provider not suffering financially, if this is what he or she wants to do;**
- **he or she should know in advance the maximum amount, in cash terms or percentage of house value, that the arrangement will cost him or her; and**
- **he or she should know in advance which, if any factors may influence the amount involved, and their relative importance. (para 184)**

The Government notes the Committee's views on the use of equity-release schemes to finance long-term care insurance and will take those views into account in reaching any decisions. The FSA covers a range of instruments, which it defines as'investments". It does not include mortgages which are a form of credit. However where an equity release scheme has an investment element, the investment is regulated under the FSA, and advisers are required to ensure that advice given on the product as a whole is appropriate to the circumstances of the investor, and to give information to the investor on the financial implications of the product.

**Recommendation 37**

**Another alternative approach ... would be to allow tax relief on the insurance premiums paid. ... PPP Lifetime Care plc told us that us that "we do not accept the need for further tax incentives for what is already a tax efficient product". We endorse this conclusion. (para 185)**

**Recommendation 38**

**The implication of the proposal to introduce a tax allowance for people who take on responsibility for making some provision for their own care is that it would allow them to avoid the current obligation for those who make private health provision to pay doubly, i.e. for public health care through general taxation as well as for their own private provision. For this reason we do not favour the proposal. (para 186)**

The Government agrees with the Committee's endorsement of the view that there is no need for a special tax relief for long-term care insurance premiums; but would not wish to close off debate on the wider question of the relationship between the tax system and the balance of responsibility between the state and individuals for making prudential provision.

**Recommendation 39**

**Any change to a funded option is subject a grave disadvantage. It would involve one generation paying twice over, both for itself in years to come via the funded scheme, and for the current generation of elderly people through taxation. Such a change would therefore need to take place over a very long time scale in order to be affordable to individuals in the "change generation". (para 193)**

The Government notes the Committee's recommendation, and will take it into account in any future consideration of this type of policy proposal.

**Recommendation 40**

**In this report we have discussed the issues which will underlie future decision-making about the provision and funding of long-term care. We have pointed out examples of good practice in the provision of such care, and have emphasised the need to expand the scope and quality of domiciliary, rehabilitative and respite care; this would benefit the individuals concerned *and* be likely to be cost-effective from the viewpoint of funding authorities. We have called on greater attention to be paid to the need to improve housing facilities for the elderly disabled, and for more effective liaison between housing, social services and health authorities. We have considered the projections currently available as to the future costs of long-term care, and concluded that there is no imminent crisis of affordability. We also express scepticism about the assumptions on which some of the gloomier predictions of escalating costs in the longer term are based. We make clear that the status quo of funding long-term care mainly from general taxation is a defensible option, which is both possible and affordable, but go onto discuss the pros and cons of possible alternative approaches. We call for the long-term care insurance market to be properly regulated. We state that until such time as the Government divulges its own estimates of the likely cost of each option—including the likely costs of its preferred option of partnership schemes—it will not be possible to reach a final decision on the best way forward. Decisions on whether long-term care should be funded through general taxation or through insurance, and if the latter whether the system should be voluntary or compulsory, touch upon fundamental questions concerning the future of the Welfare State, and cannot be tackled in relation to long-term care in isolation. (para 196)**

**Recommendation 41**

**It is clear that there is no immediate funding crisis facing the nation in respect of long- term care. There is a window of opportunity within which the national debate on this subject can proceed during the remaining years of this century and beyond. We believe there is an urgent need to establish a much better knowledge base on the costs and benefits of health promotion, rehabilitation, and preventative social care, on the impact of future demographic, medical and social developments of long-term care costs, and on the costs to the public purse of alternative funding options. Public awareness of the issues and choices involved must be improved, and we hope our report will be a contribution to that process. It is highly desirable that any major changes to current arrangements should be agreed on a basis of all-party consensus in order to provide the stable and certain background for individuals to take effective decisions about their future care. (Para 197)**

The Government welcomes the committee's input on this important and complex issue and notes especially the committee's view that there is no immediate funding crisis facing the nation in respect of long-term care. The Government shares the committee's recognition that we now have a window of opportunity to address thoroughly a range of fundamental questions on the provision and funding of long-term care. The Government is committed to ensuring the provision of quality continuing care to those who need it and will continue to regard it as a high priority to keep developments under review.

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